Staff Findings
Part I: Population Level Results

Adolescent Health in Connecticut: RBA Project 2011

December 20, 2011

Legislative Program Review
& Investigations Committee

Connecticut General Assembly

Introduction

Adolescent Health in Connecticut: Population Results

The program review committee initiated its current study of adolescent health in Connecticut, which is using a results-based accountability (RBA) approach, in March 2011. Unlike the typical program review process, information developed for this study is being provided through a series of RBA products.

In September, a staff update report containing: a working draft of the RBA framework for the study with proposed key indicators for assessing state progress on desired adolescent health care results; and a preliminary performance report card on one of the study's two focus programs, school-based health centers (SBHCs) was presented to committee members. (Current versions of the RBA framework, key indicator descriptions, and state infrastructure chart are provided in Appendices A, B, and C.) The update also included a description of parental involvement and minors' rights in Connecticut, as well as a synopsis of major themes discussed at the committee's June expert panel information forum and public hearing on adolescent health issues.

This document provides staff findings regarding *population level results* for adolescent health in Connecticut. First, in a report card format, it summarizes how the state is doing based on nine key indicators in achieving the results statement: "Connecticut adolescents have the health care services, supports, knowledge, and skills that promote optimal physical and mental well-being and success in life." This can be considered a "snapshot" of the overall health status of the state's population of young people ages 10-19.

In a second section, the "story behind" the indicator data is discussed, emphasizing efforts undertaken by four state agencies with major roles in addressing the health needs of Connecticut youth – the Departments of Public Health, Social Services, Education, and Children and Families (DPH, DSS, SDE, DCF). It is intended to highlight successes and challenges of the current state adolescent health infrastructure and serve as a foundation for findings and recommendations in the final staff report scheduled to be completed at the end of next month.

The final staff report will include additional information and analysis in the form of RBA program performance report cards for: school-based health centers funded by DPH; and the second focus program area, state-funded primary and preventive teen reproductive health services. Each program report card also will contain staff proposals for low- and no-cost ways to improve program efficiency and client outcomes (effectiveness). In addition, PRI staff recommendations addressing overarching issues that could help the state make better progress toward desired health results for Connecticut's adolescent population will be presented for the committee's consideration.

Adolescent Health in Connecticut 2011

Desired Quality of Life Results Statement:

"Connecticut adolescents have the health care services, supports, knowledge, and skills that promote optimal physical and mental well-being and success in life."

HOW ARE WE DOING? PROGRESS ON KEY INDICATORS

\+ Positive trend - Negative trend ⇔ Little/no change or mixed ? Cannot be determined

*Key Indicators**	*Progress*	*Most Current Data for Connecticut*
Mortality: Adolescent deaths, accidental and intentional, are minimized.		
All Causes *1.* **Teen fatality rate declining**	-	• Between 2003 and 2007, the most current available data, the state's death rate for youth ages 15 – 19 rose from 40 to 44 per 100,000. • Teen fatality rates vary substantially by gender and race/ethnicity; deaths among Black youths age 15-19 in Connecticut were double the rate for White teens in 2006. • Connecticut ranked 7th lowest on teen deaths among all states in 2007.
Morbidity: Diseases, including chronic conditions, and injuries among adolescents are prevented.		
Physical **2. Percent of youth overweight or obese decreasing**	⇔	• Over one-quarter of Connecticut youth ages 10-17 were overweight or obese in 2007 (26%), compared with nearly one-third (32%) nationally. • The statewide rate changed only slightly – about one percent -- between 2003 and 2007. • Disparities in Connecticut high school student obesity rates by gender and race/ethnicity are substantial.
Behavioral **3. Percent of adolescents experiencing depression declining**	⇔	• About 25% of high school students in Connecticut and in the U.S. reported they felt persistently sad or hopeless in 2009. • Prevalence rates of adolescent depression since 2005 have changed very little at state or national levels. • Rates of depression among teens are substantially higher for females than males, and also vary by race/ethnicity in Connecticut and the U.S.
Oral **4. Percent of youth with untreated dental cavities decreasing**	?	• Data for most oral health indicators, particularly trend data, are not available by state at this time. • Nationally, rates of untreated cavities among youth ages 12-17 declined from 19% in 1999 to 12% in 2008. • Nearly 85% of all children in Connecticut, compared with 78% nationally, had a preventive dental visit in 2007.

HOW ARE WE DOING? PROGRESS ON KEY INDICATORS

\+ Positive trend - Negative trend ⇔ Little/no change or mixed ? Cannot be determined

*Key Indicators**	*Progress*	*Most Current Data for Connecticut*
Health Risk Factors: Adolescent behaviors associated with poor health outcomes, particularly those with long-term negative consequences, are avoided.		
Alcohol Use **5. Binge drinking rate for youth declining**	⇔	• The binge drinking rate for high school students in Connecticut in 2009 -- 24.2% -- was the same as the national average. • Between 2004 and 2009, there has been little change in binge drinking rates for either Connecticut youth ages 12-17 (13%) or young adults ages 18-25 (47-50%).
Drug Use **6. Rate of illicit drug use (other than marijuana) for youth declining**	⇔	• Between 2004 and 2009, the use of illicit drugs among adolescents ages 12-17 decreased from 5% to 4% in both Connecticut and the U.S. • After steadily dropping since 2004, rates for youth ages 18-25, increased to 9% from 8% in 2009 in Connecticut but stayed the same nationally (8%).
Tobacco Use **7. Cigarette smoking rate for youth declining**	+	• Cigarette use among Connecticut and U.S. teens and young adults is nearly the same; between 2004 and 2009, smoking rates declined for both age groups. • Smoking rates for 12-17 year olds are much lower than rates for 18-25 year olds; rates in 2009 nationally and in Connecticut were about 9% for the younger group and around 36-37% for the older group.
Sexual Activity **8. Teen birth rate declining**	+	• Connecticut's 2008 teen birth rate of 23 per 1,000 females ages 15-19 was 4th lowest in the U.S.; the national average was 41 per 1,000. • Teen birth rates in Connecticut and the nation were lower in 2008 than in 2004. • Rates vary substantially by race/ethnicity; in 2008, births to Hispanic teens were almost three times the state average in Connecticut and nearly twice the U.S. average.
Health Protective Factors: Conditions that contribute to positive health outcomes for adolescents are promoted.		
Insurance **9. Percentage youth without health insurance decreasing**	⇔	• From 2005 through 2009, the rate of uninsured children and youth ages 6-17 in Connecticut fluctuated between 6 and 7%. • Connecticut's rate of uninsured children under 18 is substantially lower than the national rate -- 6.5% versus 9.8% in 2010. • Adolescents ages 12-17 nationwide are more likely than young children to have gaps in coverage; uninsured rates also are higher for Black and Hispanic children overall, and for children under 18 living in poverty .

*Details regarding each key indicator are contained in Appendix B.

STORY BEHIND THE DATA

The above PRI report card shows *Connecticut compares well with national data on nearly all the key indicators presented*. Teen fatality and birth rates in this state are among the lowest in the country. The portion of the adolescent population that is overweight or obese is below the U.S. average and the percent of children without health insurance is smaller in Connecticut than in most states. State rates of adolescent depression, binge drinking, and drug and tobacco use are about the same as national averages. As state-level data about teen oral health are limited, Connecticut's comparative performance in that area is difficult to assess at this time.

Other National Assessments

A number of national organizations periodically review and report on state performance on various aspects of child and adolescent health. Recent results for Connecticut from four major national assessments are highlighted below. *In general, Connecticut ranks among the top states on ratings of overall system performance, and on many specific indicators of adolescent health and well-being.*

KIDS COUNT profile. Each year, the Annie E. Casey Foundation publishes its KIDS COUNT Data Book that tracks the well-being of children and youth at national, state, and local levels.[1] Ten key indicators, which are used to monitor trends and compare state performance in important health and safety areas for children, have been followed for two decades.

Connecticut's composite ranking in 2011 on all 10 KIDS COUNT key indicators was sixth. The three best states were New Hampshire, Minnesota, and Massachusetts; the three lowest ranked states were: Mississippi, Louisiana, and Alabama. Connecticut consistently compares well with other states; it has ranked as high as three and no lower than 11 since 2002.

The state's complete Data Book profile for 2011 is provided in Appendix D. It shows Connecticut ranks in the top 10 states for all four KIDS COUNT key indicators specific to adolescents (with 1=best): teen death rate (7^{th}); teen birth rate (4^{th}); percent teens not in school and not high school graduate (3^{rd}); percent teens not attending school and not working (2^{nd}).

Commonwealth Fund scorecard. The Commonwealth Fund is a private foundation that supports independent research and provides grants to improve health care practice and policy, particularly for the most vulnerable groups in society. One of the fund's ongoing projects is compiling a scorecard that assesses core dimensions of national and state health care system performance to help policymakers and other stakeholders assess progress and identify areas in need of improvement.

The current *State Scorecard on Child Health System Performance*, released in February 2011, examines 20 key indicators across the following three dimensions: access and affordability

[1] Annie E. Casey Foundation, *2011 KIDS COUNT Data Book: State Profiles of Child Well-Being*, 2011.

of care; receipt of preventive care and treatment; and the potential to lead healthy lives. A fourth dimension incorporates a measure of system equity in terms of differences in performance on other selected indicators associated with the income, insurance type, and race or ethnicity of children and their families. The scorecard data generally cover all children under 18; while not specific to adolescents, the scorecard still provides some of the best available comparative information on how well state health care systems are meeting health care needs of children and youth.

Connecticut ranks 9th among all states in overall child health system performance. All the New England states are in the top quartile although the others rank higher than Connecticut. Massachusetts, tied with Iowa, is first; Vermont is third, Maine fourth, New Hampshire fifth, and Rhode Island 6th.

The five best performing states overall also were in the top quartile on all four dimensions of the scorecard. Connecticut's child health care system did very well on three of the four, ranking 6th both for potential for children to lead healthy lives and for equity, and 8th on access and affordability of care. However, the state placed 26th on the prevention and treatment dimension.

A copy of Connecticut's 2011 scorecard is provided in Appendix E. It shows, regarding preventive care and treatment, that Connecticut had higher rates of unmet needs for children with special health care needs and higher hospital admissions for pediatric asthma than many states. Also, the state's rates for screenings and immunizations (which are just for younger children as adolescent measures are not captured by the scorecard) were below the national median.

Connecticut ranks high on some other indicators in this dimension. Its rate of children receiving needed mental health treatment was second best among all states. The percent of those under 18 who had a preventive dental or medical care visit in the past year ranked 4th and 5th, respectively.

The scorecard report points out *all states, even high performers like Connecticut, have room for improvement*.[2] For example, top-ranked states still may not be achieving satisfactory results. Nearly a third of children under age 18 lack access to health care meeting the definition of a medical home in the states rated best on that measure.[3] Similarly, while between 82 and 96 percent of children under 18 in every state had health insurance coverage, significant numbers still lack access to quality preventive medical and dental care and do not receive recommended screenings and immunizations.

[2] The Commonwealth Fund, *Securing a Healthy Future: State Scorecard on Child Health System Performance, 2011*, February 2011.

[3] The American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association have jointly defined the "medical home" as a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.

NSCH portrait of states. The National Survey of Children's Health (NSCH) is conducted every four years by the National Health Statistics Center of the Centers for Disease Control and Prevention, under the direction of the U.S. Maternal and Child Health Bureau (MCHB). The survey asks a representative sample of parents about multiple aspects of their children's physical and mental health, health care, and social well-being, as well as aspects of their family and neighborhood that can affect health.

NSCH provides a comprehensive source of basic state-level information on health status and risk and protective factors for both children and youth. Most survey data information, however, is reported for all children under 18 or by school-age and preschool categories; little is specific to the adolescent population.

National and state level survey results are analyzed and reported by the Child and Adolescent Health Measurement Initiative (CAHMI), a research center based out of the Department of Pediatrics of Oregon Health and Science University. For 2007, key state level indicators were compared with national statistics in individual profiles, which were combined to provide a "portrait" of the health and well-being of U.S. children. In what it calls "snapshot" reports, CAHMI also examines disparities within state and national performance indicators, in terms of differences by income, race and ethnicity, insurance type, and groups with special health needs.[4]

Key indicators from the 2007 NSCH data that are most relevant to adolescent health are summarized for Connecticut and the U.S. overall in Table 1. As pointed out by CAHMI, findings are encouraging nationwide in several areas – a large majority of children, about 85 to 90 percent, according to parents' reports: are in excellent or very good health; have received an annual preventive health care check-up; and are currently insured.

Connecticut's performance on each NSCH indicator in Table 1 is better than the overall performance for the U.S. For 2007, nearly 95 percent of children under 18 in the state were currently insured and under 10 percent lacked consistent coverage during the year. About 95 percent of Connecticut children had an annual medical preventive care visit, almost 85 percent had an annual oral preventive care visit, and nearly 80 percent who needed mental health care received it. A very high proportion, 88.2 percent according to parents' reports, is in excellent or very good health. Oral health was excellent or very good for a smaller portion, but still a large majority, 76.4 percent. Fewer than five percent of Connecticut children ages 6-17 missed 11 or more days of school in 2007.

One area of concern at both the state and national levels is the portion of children who receive care in a medical home. Only about 62 percent of children under 18 in Connecticut, and a slightly smaller portion nationwide (57.5 percent), have a regular source of medical care

[4] Children and youth with special health care needs (CYSHCN) are defined by federal law as having one or more ongoing physical, developmental, behavioral or emotional condition that require more than routine care. Under the federal CYSHCN program, states receive funding that can be used to provide care coordination, advocacy, and other supports to eligible families. In 2007, children with special health needs represented about 21 percent of the Connecticut population under 18, slightly more than the national rate (19 percent). DPH administers Connecticut's program.

meeting all medical home criteria (i.e., accessible, continuous, comprehensive, coordinated, compassionate, and culturally sensitive).

Table 1. Selected Child Health and Well-Being Indicators from NSCH 2007: Connecticut and U.S.

Indicator	Explanation (*Percent of Children*:)	CT %	U.S. %
Child Health Status	*in excellent or very good health*	88.2	84.4
Oral Health Status	*with excellent or very good oral health*	76.4	70.7
Missed School Days	*aged 6-17 who missed 11 or more days of school in past year*	4.6	5.8
Current Health Insurance	*currently insured*	94.6	90.9
Insurance Coverage Consistency	*lacking consistent coverage in past year*	9.1	15.1
Preventive Health Care	*with a preventive medical visit in past year*	95.2	88.5
Preventive Dental Care	*with preventive dental visit in past year*	84.9	78.4
Mental Health Care	*aged 2-17 with problems requiring counseling who received mental health care*	78.8	60.0
Medical Home	*who received care in a medical home*	62.4	57.5

Source of Data: U.S. DHSS, Health Resources and Services Administration, Maternal and Child Health Bureau. *The National Survey of Children's Health 2007,* Rockville, MD, 2009.

Further, performance on the medical home indicator and the key NSCH indicators, at both the national and state levels, vary substantially by race, ethnicity, and family income. CAHMI analysis shows White children generally have better health outcomes and services than children of other races. Also, low-income children overall are less likely to have positive survey findings (e.g., be in excellent or very good health, have consistent insurance coverage, receive care in a medical home).

NCCP adolescent profile. As part of an ongoing project called "Improving the Odds for Adolescents," the National Center for Children in Poverty (NCCP) at Columbia University compiles information about state policy choices that affect the health and well-being of adolescents. In a recent report (June 2011), the center examined whether states have adopted the policies its research has shown promotes adolescent access to high quality health, mental health, violence and injury prevention, and positive youth development services. [5]

According to NCCP, such policies include the following steps states have taken to:

[5] National Center for Children in Poverty, Mailman School of Public Health, Columbia University, *Connecticut Adolescent Profile,* Updated June 1, 2011.

- expand public health insurance coverage to reach more youth in need of care;
- push schools to adopt evidence-based health promotion curricula and programs;
- mandate a coordinated school health approach;
- invest in SBHCs and other best practices shown to improve health and academic outcomes;
- explicitly extend consent and confidentiality rights to adolescents around sensitive topics (e.g., mental health, reproductive health;
- empower adolescents to protect themselves from violence and abuse (e.g., access to protection orders, bullying and cyberstalking legislation);
- encourage public-private collaborations to expand internships, mentoring, and other growth opportunities; and
- invest in programs that enable adolescents, particularly vulnerable youth, to successfully transition to independent adulthood (e.g., vocational and independent living skills training, counseling).

Based on the adolescent profile for the state in the center's 2011 report, Connecticut has adopted about two-thirds of 78 specific state policies and practices associated with improved access to and quality of health services for adolescents.

The majority of policies associated with access to quality health care (21 of 27), some of which are funding school-based health centers, providing continued Medicaid eligibility for youth aging out of the foster care system, and laws allowing minors to consent to various reproductive health services, are in place in Connecticut. About half the policies identified by NCCP as promoting mental health care access and quality (6 of 11), such as requiring certification of school behavioral health staff and mandating drug and alcohol use prevention as part of school health education curriculum, also are in place in the state.

Connecticut also has adopted half (11 of 22) of the violence and injury prevention policies outlined in the NCCP report, including a graduated driver licensing system as well as a ban on cell phone use by novice adolescent drivers. Most of the policies concerning positive development (10 of 13), which range from various supports for foster youth transitioning to adulthood to a mandatory minimum high school completion age of 18, are state law or established practice in Connecticut.

Previous State Assessments

Findings from two prior state efforts to evaluate adolescent health in Connecticut, a strategic planning initiative and an advisory council review, are highlighted below. For the most part, the issues, priorities, and proposed changes identified by the council more than 15 years ago are echoed in the strategic plan prepared about 10 years later.

State adolescent health strategic plan. The last comprehensive assessment of adolescent health in Connecticut was carried out as part of a state adolescent health strategic

planning process completed in May 2005. The planning process, led by the Department of Public Health, was undertaken in response to the National Initiative to Improve Adolescent Health by 2010.

The department received assistance from an outside consultant and a committee of key stakeholders, including representatives from six state agencies with major roles in adolescent health, the legislature's Medicaid council, various types of health care providers, and several children and youth advocacy organizations. In addition to helping the committee prepare the plan, the consultant conducted a needs assessment and a best practices review, and compiled an inventory of existing adolescent health system assets.

A key finding from the planning process was: "*Overall, Connecticut adolescents do well on many health factors compared to the nation, with trends generally improving. However, significant disparities exist for youth of specific racial and ethnic groups, age groups, or gender for particular health issues, suggesting that there are important opportunities to further improve adolescent health in the state*."[6]

The 2005 strategic plan found Connecticut has available a wide range of programs and services, public and private, addressing adolescent health. However, many challenges to effective coordination of policies and programs, such as limited opportunities for exchanging information or collaborating on service delivery, also were found. It was noted no suitable mechanism for sharing confidential health care information across providers and agencies was in place.

In addition, a number of data deficiencies that impede effective planning and accountability were identified by the strategic planning process. Much of the available data about adolescent health needs and services were incomplete, outdated, and not representative; mental health data were particularly limited. Few if any data were systematically collected about the health of youth who were homeless or not in school, the most at-risk group for poor outcomes. A central data warehouse and centralized process for monitoring program and system effectiveness also were found missing.

In the final state strategic plan, the department and the planning committee identified the following three issues and associated goals as top priorities for supporting adolescent health and positive development in the coming decade:

1. ***Provide the support, options, and resources adolescents need to successfully transition to adulthood.***
    - Teens empowered to assume responsibility for health and behavior.
    - Access to timely, affordable, appropriate health and mental health services ensured.

2. ***Enhance communication, coordination, collaboration among stakeholders in adolescent health.***

[6] Connecticut Department of Public Health, *Connecticut Adolescent Health Strategic Planning Initiative: A Report on Adolescent Health Needs, Assets and Best Practices* (prepared by Policy Studies Inc.), May 2005, p. 4.

- Data and information, particularly on lessons learned, best practices, challenges, and successes, shared across programs/service providers and agencies.
- All health services adolescents receive coordinated and integrated.
- Appropriate data collected and made available to inform decision-making at program and system levels.

3. ***Improve adolescent health and well-being.***
   - ***Obesity and healthy lifestyles***: healthy nutrition/fitness promoted.
   - ***Mental health***: prevention/positive mental health programs available; access to and use of appropriate services when needed ensured.
   - ***Substance abuse***: youth abstain from drug/alcohol use; ensure access to timely, affordable, appropriate treatment when needed.
   - ***Reproductive health***: youth adopt behaviors that support healthy sexuality.
   - ***Violence***: adolescents' neighborhoods and schools are violence-free.

The strategic plan contains other proposed systemic improvements and specific interventions, as well as a general framework for implementation. Recognizing success is dependent on a collective effort by all partners, especially the state education department, the framework calls for: establishment of an implementation group with general oversight responsibilities for moving the plan forward; formation of teams to develop action plans and monitor progress on each priority and strategic issue; and the appointment of a strategic planning coordinator to facilitate implementation efforts.

Some efforts to organize the implementation group and develop action teams did occur soon after the plan was completed in 2005; however, to date there has been no comprehensive follow up. At this time no one within the public health department or any other state agency is assigned to monitor implementation or update the current adolescent health strategic plan.

Adolescent health council report. The State-Wide Adolescent Health Council was established by the legislature in 1992 (P.A. 92-107) to advise and consult with the commissioners of public health, social services, education, and children and families, about teen health needs and coordination of service delivery. Council members included heads of the various state agencies involved with adolescents, chairs of the legislature's public health and human services committees, and representatives of a number of provider groups, social service agencies, and advocacy organizations that serve adolescents.

The adolescent health council also was charged with examining issues related to high risk behaviors, such as teen pregnancy, substance abuse, AIDS, and violence, and making recommendations to address these and other health needs of Connecticut adolescents. As mandated by law, the council issued a report to the legislature in 1994 that contained its findings and recommendations about adolescent health in Connecticut.

In its report, *the council identified a number of problems with adolescent health in Connecticut* and the U.S., including the following main findings:

- Adolescent health services have not been a public policy priority due to the false impression teens generally are healthy; nationwide, adolescents are the only age group for whom life expectancy is declining.

- Multiple barriers impede access to health services, including lack of providers trained in adolescent health care, lack of information on available services, and teens' concerns about confidentiality.

- Adolescents do not seek timely care when they cannot pay for it, easily reach it, or believe providers might inform their parents against their wishes for privacy.

- Significant numbers of adolescents lack health insurance coverage (one in seven at the time); many private insurance plans do not cover services youth need, such as treatment for mental health and substance abuse problems or preventive services such as contraception.

- Despite research findings showing adolescent health problems often are multi-faceted (e.g., physical, behavioral, social) and require comprehensive approaches to care, most state policies and funding for adolescent health services is categorical (focused on a single problem, such as substance abuse, risky sexual activity, and smoking).

- Adolescent health issues are currently addressed by multiple agencies, providers, and a wide range of community-based organizations with little evidence of effective cooperation and coordination. There is no locus for oversight of adolescent health planning and program development and no "voice" for adolescent health issues in health care debates.

- Health trends for adolescents are not tracked for the purposes of efficient health policy planning and evaluation; available indicators of teen health often lag three to four years and some critical data are not available at all.

To address these problems, the council made five main recommendations: 1) improve access to health services; 2) ensure adequate financial reimbursement and insurance coverage for health services; 3) establish and evaluate comprehensive preventive services; 4) centralize planning and oversight responsibilities; and 5) establish an adolescent health index to track trends. The 1994 report also outlined the council's immediate priorities for specific actions by state agencies and policymakers within each of these areas, including:

- expansion of school-based health centers;

- support community-based services for hard-to-reach populations (e.g., school dropouts, homeless youth);

- expansion of Medicaid coverage to more low-income youth and support for efforts that can increase adolescent participation in EPSDT ;

- fund comprehensive prevention programs aimed at reducing all targeted risk behaviors and developed via inter-agency collaboration;

- mandate accurate and comprehensive K-12 health education that emphasizes risk reduction skills;

- establish the council as the central entity responsible for coordinating services, increasing communication and collaboration, advocating for adolescent health, developing a comprehensive state plan for adolescent health care, and making recommendations to public health and other state agencies for enhancing adolescent health; and

- establish one standardized statewide data collection system for monitoring incidence and prevalence of adolescent health issues, analyzing trends, assessing risk and protective factors, and tracking service utilization to identify gaps and priorities.

It appears the council issued no further reports (and was not required to) and there are no records of meetings or other activities following submission of the 1994 report. The council had been defunct for a number of years at the time PRI began this study and its enabling legislation was repealed during the 2011 regular legislative session (P.A. 11- 242).

HUSKY Program Monitoring and Evaluation Results

Two programs administered by the Department of Social Services are the major publicly funded source of health care services for Connecticut adolescents:

- HUSKY A, the state's Medicaid program for low-income children up through age 18 (and their caregivers, as well as certain pregnant women); and

- HUSKY B, Connecticut's Children's Health Insurance Program (CHIP) for uninsured children not eligible for Medicaid but whose family income is below thresholds set by the state.

According to DSS, one of every five children in Connecticut is covered by the HUSKY programs or another department health plan. An estimated 117,000 adolescents ages 10-19 are covered by HUSKY A; about another 9,000 youth in this age group are enrolled in HUSKY B.

Every child and adolescent on Medicaid is eligible for Early Periodic Screening, Diagnosis and Treatment (EPSDT) up to age 21. EPSDT is a federally mandated program of comprehensive preventive health services provided in accordance with American Academy of Pediatrics guidelines (i.e., "Bright Futures"). The program's goal is early identification and treatment of conditions that can impede children's healthy growth and development and avoidance of the costs, human and financial, of long-term disability.

EPSDT services include required well-child checkups with a variety of screenings (medical, dental, vision, and hearing), assessments of physical and behavioral/developmental

status, and appropriate immunizations. States also must provide diagnostic and treatment services for all medically necessary health needs identified by EPSDT, whether or not the services are covered benefits of their Medicaid programs. As a result, Medicaid coverage for children is more comprehensive than the benefits provided for adults or through typical private insurance plans.

High enrollment in Medicaid and CHIP programs, and full participation in EPSDT, are crucial ways for states to achieve good health results for children and youth and a cost-effective public health care system. In Connecticut, ensuring access to, and utilization of, the HUSKY programs is a central strategy for meeting the health needs of the state's most vulnerable children and youth (e.g., low-income, uninsured, involved in the child welfare or juvenile justice systems).

Since 1994, the statutory Medicaid Medical Assistance Program Oversight Council (originally known as the Medicaid Managed Care Council), has been responsible for advising on development and overseeing implementation of Connecticut's Medicaid, and later CHIP, health services programs for children and families. Current council membership consists of legislators, state agencies, consumers, advocates, and health care providers. Representatives of the state's contracted managed care organizations (MCOs) and administrative services organizations (ASOs) for HUSKY and other DSS medical assistance programs also serve on the council.

Under legislation enacted in 2011 the council's oversight role was expanded to encompass the programs covering all Medicaid enrollees in the state (P.A. 11-44). The council also was given responsibility for monitoring and advising DSS on matters related to the end of all managed care arrangements on January 1, 2012, and transition to an ASO model for all medical services. (Behavioral health and dental services for Medicaid enrollees already are administered through contracted administrative services organizations.)

Since it was established, the Medicaid council, often through various working committees, has regularly reviewed HUSKY and other program performance data provided by the department and the contracted program managers and administrators. It has requested preparation of special reports and held forums on issues of concern, including, in the early 2000s, adolescent underutilization of EPSDT services.

The council also receives the reports and research briefs prepared by the department's contracted, independent HUSKY program evaluator, Connecticut Voices for Children (CVC). Recent council and CVC monitoring and evaluation results related to how well the HUSKY programs are meeting adolescent health needs are described briefly below. Some supplemental performance information provided by DSS also is included.

Findings related to two key aspects of accessibility – enrollment and utilization rates – for youth ages 10 to 19 are highlighted. Overall, these data underscore the importance of initiatives that have been shown to improve adolescent access to, and utilization of, primary and preventive care, such as school-based health centers and community-based teen pregnancy prevention programs.

Enrollment. Data presented by Connecticut Voices for Children at the program review committee's June information forum showed in 2009 (the most recent available data), a total of 126,899 children ages 10 -19 were enrolled in HUSKY at least one point; 65 percent were enrolled for the entire year. While the average period of enrollment for this group was 10 months, the CVC analysis found older adolescents were less likely to be continuously enrolled and had shorter average enrollment periods.

Research conducted by CVC in 2010 showed that some of the gaps in coverage for older teens can be the result of administrative error by the Department of Social Services.[7] Based on data from 2006-2007, one in six of children turning 18 (15.9 percent) lost HUSKY A program coverage, a disenrollment rate eight times higher than for youth ages 10 or 15. It appears in some cases disenrollment of the older teens was triggered incorrectly due to their age. Prior to 1996, eligibility ended at 18 for children not enrolled in school; however, subsequent rule changes provide children with HUSKY coverage until their 19th birthday. Some reasons given for mistaken disenrollment are long-standing problems at DSS: outdated technology, inadequate procedures, and confusing notification forms.

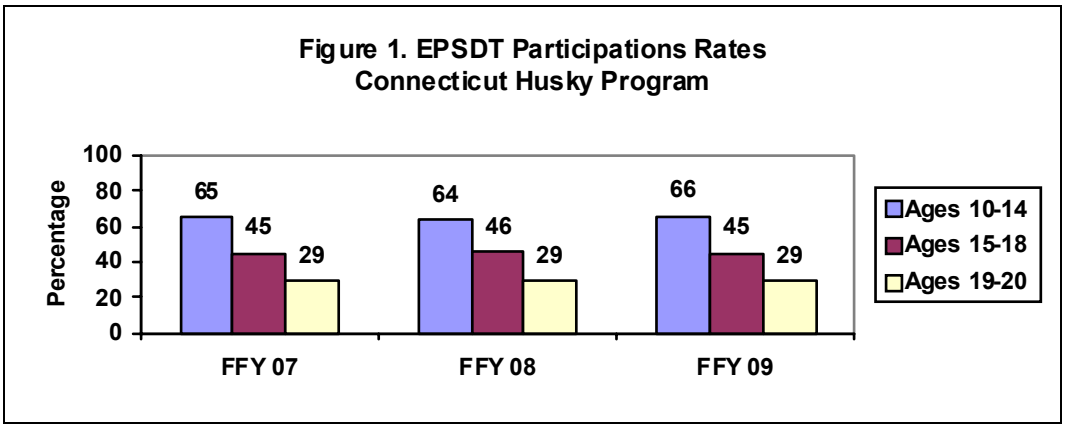
Utilization. An October 2000 study of EPSDT services by the department's external quality review contractor (Qualidigm) found very low utilizations by adolescents in the HUSKY program. While in 1998 and 1999 participation rates were in the mid-60 percent range for children up to age 10, they dropped precipitously to between 30 and 40 percent for older youth. The study also found, based on 1998 data, only 28 percent of youth ages 12 to 21 had a well care visit during the year; 33 percent had documentation of an acute care visit only; and 16 percent had no service documentation.

In response to these findings, the Medicaid council organized a work group focused on increasing adolescent EPSDT participation and making teen well care visits more comprehensive. During 2002 and 2003, the group worked with HUSKY program MCOs and the department to develop action plans for improving access to and quality of adolescent preventive care services. Final plans were presented and favorably reviewed by the council at its May 2004 meeting.

However, recent data on adolescent EPSDT participation rates, provided at the PRI committee's June forum by DSS, indicates no improvement since the 2000 study findings. As Figure 1 shows, participation rates remain at 64 to 66 percent for young adolescents (ages 10-14) between 30 and 40 percent for older teens (15–20). The department cautions against trying to interpret these data any further without a full understanding of the limitations of the EPSDT measures and adolescent health care utilization patterns.

Connecticut Voices for Children presented the most recent available information on preventive care use by adolescents enrolled in HUSKY at the PRI committee's June information forum. Based on its analysis of 2008 claims data, CVC found 83 percent of children ages 10 to 19 had a primary care provider visit but only 50 percent had a routine check up (well-care visit). In 2008, 44 percent of adolescents had preventive dental care.

[7] Connecticut Voices for Children, *Husky Program Coverage for 18 Year Olds: Recommendations for Avoiding Gaps or Loss of Coverage*, October 2010.



Use of preventive care, however, declined with age and varied by gender; significantly fewer teens over 16, particularly males, compared with younger adolescents had routine check-ups during 2008. CVC also found one in three adolescents had received emergency care, with utilization rates higher for older teens. One in four adolescents with any emergency care in 2008 was treated for a condition that could have been prevented or treated by a primary care provider.

The most recent available information on inpatient care received by HUSKY teens, provided by DSS at the committee's June information forum, is summarized in Table 2. It also indicates more can be done to ensure adolescents use primary and preventive services, such as EPSDT, particularly in the areas of reproductive and behavioral health.

Table 2. HUSKY Members Ages 13-20: Top 5 Categories of Inpatient Care CY 2009

Major Diagnostic Category	No. Admissions	% Total Admissions	Total Payments ($ millions)
HUSKY MCO INPATIENT DATA – PHYSICAL HEALTH ONLY			
Complications of Pregnancy & Childbirth	2,843	58	$10.364
Digestive System Disease	395	8	$ 1.984
Injury & Poisoning	353	7	$ 1.921
Respiratory System Disease	239	5	$ 1.252
Blood Disease	134	3	$ 1.444
Total all categories	*4,866*		*$22.958*
HUSKY FFS INPATIENT DATA - COMBINED PHYSICAL & BEHAVIORAL HEALTH			
Mental Disorders	2,434	63	$33.645
Complications of Pregnancy & Childbirth	628	16	$ 2.331
Injury & Poisoning	174	5	$ 1.762
Digestive System Disease	143	4	$ .677
Respiratory System Disease	80	2	$ .611
Total all categories	*3,848*		*$42.172*

Source of Data: DSS PowerPoint Presentation to PRI, June 21, 2011.

The top part of the table shows the five categories for inpatient physical health services provided in 2009 to adolescents ages 13-20 who are enrolled in HUSKY MCOs. Complications of pregnancy and childbirth accounted for well over half of all admissions (58 percent) and $10 million of the total $23 million in payments.

The bottom part of Table 2 presents similar information for the department's fee-for-service (FFS) medical assistance programs that serve youth, which includes all behavioral health services. In 2009, over 2,400 adolescents covered by HUSKY received inpatient care for mental disorders at a cost of almost $34 million. The top physical health reason for inpatient admissions within this group of teens was complications of pregnancy and childbirth.

Adolescent Health: Critical Elements

As discussed earlier, Connecticut's current policies and existing adolescent health infrastructure are achieving good results, based on available data, relative to other states and national statistics. Furthermore, the state has made some steady progress on several key indicators of adolescent health. Connecticut teen birth rates and rates of cigarette use by teens have been dropping. Also, with the availability of the state's HUSKY programs, the portion of children without health insurance in Connecticut also has declined significantly over the past decade.

In other indicator areas, however, progress seems stalled. Rates of adolescent depression, binge drinking and illicit drug use among youth, and teen overweight and obesity rates, have shown little change in the past few years. Perhaps more troubling is the increase between 2003 and 2007 in the state's teen fatality rate. Persistent and substantial racial and ethnic disparities within most key indicators of adolescent health, while not unique to Connecticut, are of concern.

To better understand the reasons for plateaus and variations in performance, as well as ways to achieve better results, PRI staff reviewed the recent research about effective adolescent health policies and systemic practices.[8] Elements considered by experts to be critical for successful state adolescent health systems were identified from three main sources: a 2009 report by the National Research Council and Institute of Medicine (IOM); a 2008 American Academy of Pediatrics (AAP) policy statement; and a conceptual framework developed by the Association of Maternal and Child Health Programs (AMCHP) in collaboration with the National Network of State Adolescent Health Coordinators (NNSAHS).[9]

[8] Informally, these elements might be referred to as "best practices" for adolescent health. However, for purposes of this study, staff decided to limit use of that term, as suggested by the National Adolescent and Young Adult Health Information Center (NAHIC), to evidence-based strategies, activities, and/or approaches shown through experimental research to be effective. There are a number of evidence-based adolescent health programs and services in use (including several under review by this study that will be discussed in the final report). However, system-level approaches have not been subject to the rigorous research required for formal best practice designation at this time.

[9] See: National Research Council and Institute of Medicine (2009), *Adolescent Health Services: Missing Opportunities*. Washington, D.C.: The National Academies Press; American Academy of Pediatrics. *Policy Statement: Achieving Quality Health Services for Adolescents*. Pediatrics Volume 121, Number 6, June 2008; *A Conceptual Framework for Adolescent Health* (May 2005). A Collaborative Project of the Association of Maternal

The concepts and themes emphasized by all three sources vary mainly in presentation. Critical elements for quality adolescent health are outlined as five objectives by the Institute of Medicine, seven criteria by the American Academy of Pediatricians and 10 guiding principles by AMCHP/NNSAHS. However, taken together, they can be summed up in three broad categories: accessibility; coordination; and quality.

Accessibility. Research shows for adolescents, the key determinants for accessing health care services are convenience, cost, and confidentiality. Offering affordable care in times and places accessible to youth is crucial to adolescent health program success.

Confidentiality issues have been shown to be significant barriers to teens obtaining necessary services in a timely way. Adolescents who want to keep sensitive health care concerns private from parents may withhold information from providers, delay entry into care, refuse care or not even seek it. Health care professionals and other experts strongly believe adolescents should be encouraged to involve their families in health decisions. However, balance also is needed to ensure confidentiality when necessary to protect an adolescent's health and well-being.

Other elements of accessibility include making care acceptable to youth by ensuring services are culturally competent, family centered, and community-based. Flexibility, within services, staff, and sites, is needed to address developmental, cultural, ethnic, and social diversity among adolescents. Above all, systems must be equitable, meaning eligibility and service delivery is unrestricted.

Coordination. To meet the health needs of adolescents, services must be comprehensive, combining health promotion, disease prevention, and youth development approaches. Best results are achieved when health services are interdisciplinary, linked, and coordinated. This requires collaboration and partnerships across providers and within communities. Effective coordination is dependent on comprehensive strategic planning and a commitment to improving adolescent health and well-being.

Quality. For adolescents, quality means strong primary care that emphasizes development, behavioral health, and disease prevention. Quality also means a basic level of service that fulfills their needs is provided to all youth. Care provided should be scientifically supported and appropriate. Sound data and strong analytic capacity are essential to high quality programs, services, and delivery systems for adolescent health.

Initial Staff Findings

In terms of critical elements for better adolescent health results, PRI staff found several areas of weakness in Connecticut's current system. Deficiencies center around: statewide coordination and leadership; access and utilization; and adequate data for planning and accountability.

Statewide coordination and leadership. A concerted effort among many public and private partners is needed to provide quality care and improve health outcomes for all

and Child Health Programs and the National Network of State Adolescent Health Coordinators with support from the Annie E. Casey Foundation.

adolescents in Connecticut. At a minimum, DPH, SDE, DSS, and DCF need to be working together to meet the health needs of youth ages 10 to 19. Ideally, the Judicial Branch, Department of Mental Health and Addiction Services, and the successor to the Department of Higher Education also should be actively involved in planning and implementing state adolescent health strategies.

However, as cited in previous assessments and discussed at the PRI committee's information forum and public hearing, there is no strong coordinating mechanism for adolescent health in Connecticut. An up-to-date comprehensive planning document and overarching policies to guide state strategies also are lacking. Further, there is no ongoing, systematic way to track progress and hold agencies and programs accountable for achieving desired results.

Past efforts to foster coordination and promote leadership for adolescent health have not been sustainable. The legislature created the Adolescent Health Council in 1992 to direct and oversee comprehensive and coordinated state policies and programs for teen health and well-being. However, it accomplished little following its 1994 report and was recently eliminated.

In 2004-2005, DPH developed a comprehensive strategic plan for improving adolescent health, and a well-designed collaborative way to implement it, that has essentially been ignored. Within the department, there has been little focus on the adolescent population as a whole since the plan was released in May 2005. At this time, the agency position of adolescent health coordinator is inactive. (In conversations with committee staff, the commissioner, who has been with the department less than one year, indicated she plans to give increased attention to several adolescent health issues in the future.)

It is not clear why efforts to better coordinate adolescent health statewide failed to maintain momentum. PRI staff will present additional findings and any recommended changes in the final report.

Access and utilization. The rate of children and youth with health insurance coverage in Connecticut is relatively high (almost 94 percent in 2010), making access to care less of a problem than in most states. However, the fact that as many as 49,000 children under 18 are without coverage needs more attention, given the broad availability of HUSKY and other state assistance programs.[10] As discussed earlier, continuity of coverage also seems to be a problem for older adolescents enrolled in HUSKY.

There have been ongoing efforts to increase participation in HUSKY and make eligibility "seamless." For example, the state uses federal funding for outreach worker positions in the community and recently mandated schools to identify children without health insurance and provide their parents with information about the availability of HUSKY A and B (P.A. 07-2). It seems likely more can be done.

For example, a recent study by the American Academy of Pediatrics shows the percent of Connecticut children eligible for Medicaid and CHIP who are enrolled was 69.2 percent in 2008. This is about the same as the national rate (68.8 percent). However, other New England states

[10] Connecticut Voices for Children, *Uninsured Children in Connecticut: 2011*, October 2011.

had much higher rates: Maine was 82.4 percent and Massachusetts was 81.0 percent. Reasons for their better performance could be explored.

Connecticut, like other states, continues to have problems with underutilization of primary and preventive care services by adolescents who have health coverage. Critical elements for increasing use of services by teens are convenience and cultural competence. Research shows providing services in schools and other community settings are among the most effective ways to increase access for and utilization by teens, particularly low-income and minority youth. Connecticut funds a number of school-based health centers and supports some community-based reproductive health programs. As part of this study, PRI staff have been examining the effectiveness of these programs and findings and recommendations will be included in the final report.

Adequate data. Both prior assessments of Connecticut adolescent health found existing data sources for most indicators and measures have a number of shortcomings and certain information is not even collected. Some deficiencies, such as the need for more frequent national surveys and better consistency in age groupings, are being addressed at the federal level. Other steps, such as automation of existing school health assessment forms and better linkages of state data systems, can be undertaken by state agencies.

None of the state agencies with significant roles in adolescent health, however, have strong internal capacity for data collection and analysis. DSS, for example has few staff resources dedicated to Medicaid data analysis and efforts also are hampered by antiquated technology. Both contribute to data quality problems and long lags in reporting on program information. The department's contractor, Connecticut Voices for Children, has been a critical resource for analysis of HUSKY program performance, but even its work is impeded by data delays. The most recent Medicaid data provided by the department is three years old.

At this time, no state entity is responsible for systematically tracking the well-being of the adolescent population. Even with centralized oversight, better data and data sharing will be needed to determine whether Connecticut youth are better off because of the state-supported health care they receive. Staff data development and research agenda recommendations these and other data-related issues will be included in the final report.

Appendices

A. RBA Framework: Connecticut Adolescent Health (PRI Working Draft)

B. Adolescent Health in Connecticut: Key Indicators

C. State Adolescent Health Infrastructure (12/2011 rev.)

D. 2011 KIDS COUNT Profile: Connecticut

E. 2011 Commonwealth Fund Scorecard: Connecticut

Appendix A.

CONNECTICUT ADOLESCENT HEALTH

TARGET POPULATION: YOUTH AGES 10 – 19 YEARS

POPULATION LEVEL ACCOUNTABILITY

QUALITY OF LIFE RESULTS STATEMENT:

"***Connecticut adolescents have the health care services, supports, knowledge, and skills that promote optimal physical and mental well-being and success in life.***"

KEY INDICATORS
of Progress Toward Population Level Results

Mortality	Morbidity	Risk Factors	Protective Factors
(Accidental and Intentional Death)	(Disease, Chronic Conditions)	(Unhealthy Behaviors)	(Conditions Promoting Health)
1. Teen Fatalities: All Causes	***2. Physical: Obesity*** ***3. Behavioral: Depression*** ***4. Oral: Untreated Cavities***	***5. Binge Drinking*** ***6. Illegal Drug Use*** ***7. Tobacco Use*** ***8. Teen Births***	***9. Insurance coverage***

MAJOR STATE STRATEGIES
for Achieving Results Statement

Increase access to appropriate, timely, cost-effective care	***Promote use of primary and preventive care***	***Promote healthy behaviors and positive youth development***	***Better coordinate and integrate services and supports***	***Enhance data collection, research, information-sharing, accountability***

MAIN PARTNERS
Sharing Responsibility for Achieving Results Statement

Congress and Federal Agencies (ED, HHS – CDC/ HRSA/SAMSHA, IOM) Connecticut General Assembly and State Agencies (CSSD/JUD, DCF, DOC, DDS, DOL, DMHAS, DMV, DPH, DSS, DOT, OCA, OPM, SDE)	Municipal agencies (e.g., local police, health departments, YSBs) Community-Based Organizations (e.g., YMCAs/YWCAs) Public and Private Schools, Local Churches Health Care Professionals and Providers	Parents, Guardians, Families, Youth Advocacy Groups (e.g., CVC, CCA)/Foundations Health Advisory Groups (e.g., Medicaid Care Oversight Council, CBHAC)

PROGRAM LEVEL ACCOUNTABILITY

MAIN STATE AGENCY ROLES AND PROGRAMS (PRI STUDY FOCUS PROGRAMS IN RED)

Health Care Services				Health Education	Prevention	Nutrition & Fitness
Physical	**Behavioral**	**Oral**	**Reproductive**			
- ***SBHCs (DPH)***	- *HUSKY- BHP/ Medicaid LIA (DSS)*	- *HUSKY DHP/ Medicaid LIA (DSS)*	- *SVIP (DPH)*	- *School Health Ed. (SDE)*	- *Youth Suicide Advisory Comm. (DCF)*	- *School Nutrition (SDE)*
- *CHCs (DPH)*	- *State mental health & substance abuse services and facilities for all under 18 (DCF) & 18-19 (DMHAS)*	- *Oral Health Office (DPH)*	- *STD Control (DPH)*	- ***SBHCs (DPH)***	- *Healthy Start (DSS)*	- *School Physical Ed. (SDE)*
- *CSH (DPH/SDE)*	- ***SBHCs (DPH)***	- ***SBHCs (DPH)***	- ***Fam. Planning (DPH and DSS)***	- *CHCs (DPH)*	- *NFN (DSS)*	- *SNAP (DSS)*
- *CYSCHN (DPH)*	- *CHCs (DPH)*	- *CHCs (DPH)*	- ***TPPI (DSS)***	- *CSH (DPH/SDE)*	- *Youth Service Bureaus (SDE)*	- *WIC (DPH)*
- *Asthma (DPH)*	- *CSH (DPH/SDE)*	- *CSH (DPH/SDE)*	- *SPPTP (SDE)*	- *HHS (DPH)*	- *HIV Prev. (DPS)*	- *NPAO (DPH)*
- *Family/MCH(DPH)*	- *CYSCHN (DPH)*	- *CYSCHN (DPH)*	- *PREP (DPH)*		- *Tobacco(DPH)*	- ***SBHCs (DPH)***
- *HUSKY/Medicaid LIA (DSS)*	- *School Behavioral Health (SDE)*		- *Preg. & Parenting Girls (DCF)*		- *Immunizations (DPH)*	- *CHCs (DPH)*
- *School Health- public & nonpublic (SDE)*			- ***SBHCs (DPH)***		- ***SBHCs (DPH)***	- *CSH (DPH/SDE)*
			- *CHCs (DPH)*		- *CHCs (DPH)*	
			- *CSH (DPH/SDE)*		- *CSH (DPH/SDE)*	
			- *HUSKY/ Medicaid LIA (DSS)*			

CORE PROGRAM PERFORMANCE MEASURES (FOR FOCUS PROGRAMS):

School-Based Health Centers

- *Access to primary and preventive care (e.g., enrollment rates, particularly for uninsured/underinsured students)*
- *Improved health status (e.g., receive screenings, chronic conditions managed)*
- *Better school attendance (e.g., fewer absences/tardy, higher return to class rate)*
- *Cost-effectiveness (e.g., reduced use of emergency departments)*

Primary and Preventive Teen Reproductive Health Services

- *Sexual activity (e.g., delayed initiation, abstinence, contraceptive use, if active)*
- *Unintended pregnancy (e.g., lower rates)*
- *Sexually Transmitted Disease (e.g., lower infection rates, early treatment)*

Appendix A

Acronyms Used in Adolescent Health Care RBA Framework	
State Agencies	
• CSSD/JUD	Court Support Services Division, Judicial Branch
• DCF	Dept. of Children and Families
• DOC	Dept. of Correction
• DDS	Dept. of Developmental Services
• DOL	Dept. of Labor
• DMHAS	Dept. of Mental Health and Addiction Services
• DMV	Dept. of Motor Vehicles
• DPH	Dept. of Public Health
• DSS	Dept. of Social Services
• DOT	Dept. of Transportation
• OCA	Office of the Child Advocate
• OPM	Office of Policy and Management
• SDE	State Dept. of Education
Federal Agencies	
• ED	U.S. Dept. of Education
• HHS	U.S. Dept. of Health and Human Services
○ CDC	Centers for Disease Control and Prevention
○ HRSA	Health Resources and Services Administration
○ SAMHSA	Substance Abuse and Mental Health Services Administration
• IOM	Institute of Medicine of the National Academies
Advocacy /Advisory Groups	
• CBHAC	CT Children's Behavioral Health Advisory Council
• CVC	CT Voices for Children
• CCA	CT Center for Children's Advocacy
Other	
• YSBs	Youth Service Bureaus
State Programs	
• BHP	Behavioral Health Partnership
• CHC	Community Health Centers
• CSH	Coordinated School Health
• CYSHCN	Children and Youth with Special Health Care Needs
• DHP	Dental Health Partnership
• LIA	Low Income Adult (Medicaid program)
• MCH	Maternal and Child Health
• NFN	Nurturing Family Network
• NPAO	Nutrition, Physical Activity and Obesity
• PREP	Personal Responsibility Education Program
• SBHC	School-Based Health Centers
• SNAP	Supplemental Nutrition Assistance Program (formerly Food Stamps)
• SPPTP	Support for Pregnant and Parenting Teens Project
• STD	Sexually Transmitted Disease Control program
• SVIP	Sexual Violence Intervention and Prevention program
• WIC	Women, Infant, and Children program

INDICATOR AREA: MORTALITY

1. Teen Fatalities

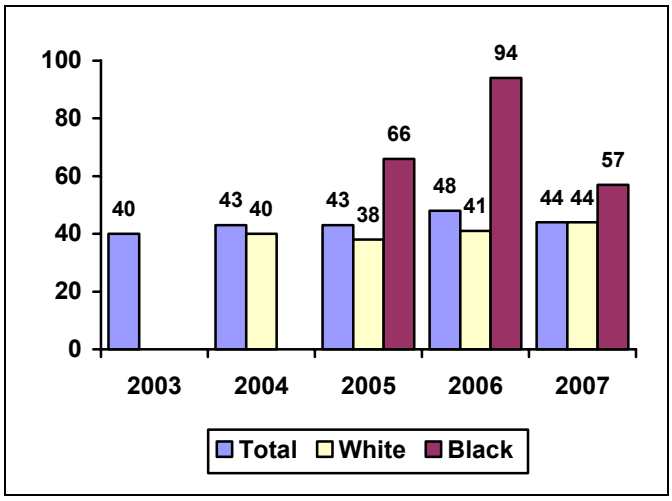
Teen death rate per 100,000 age 15-19 all causes

Data Source: CDC, National Center for Health Statistics as provided by KIDS COUNT 2011

Teen fatality rates are widely used indicators of adolescent well-being. Nationally, accidental and intentional injuries cause nearly 80% of deaths among adolescents aged 15-19. Motor vehicle crashes and other unintentional injuries, homicide, and suicide are the leading causes of death for youth and young adults aged 10-24 in the U.S. and Connecticut. Fatality rates overall and by cause vary by race/ethnicity and gender.

Possible Secondary Indicators: Fatalities by cause (motor vehicle crashes, other unintentional injuries, homicide, suicide) – all by gender, race/ethnicity

Connecticut Teen Death Rate
(per 100,000 ages 15-19)



- Between 2003 and 2007, the most recent available data, Connecticut's overall teen fatality rate rose from 40 to 44 per 100,000 youth ages 15-19.
- Fatality rates for Black youth ages 15-19 are substantially than for White teens nationally and in Connecticut; the state rate for Black teens was double that of White teens in 2006.
- Among all states in 2007, Connecticut ranked 7th lowest on teen deaths per 100,000; the state with lowest rate was Vermont (35) and highest was Alaska (100).

INDICATOR AREA: MORBIDITY
PHYSICAL, BEHAVIORAL, AND ORAL HEALTH CONDITIONS

2. Obesity (Physical Health)

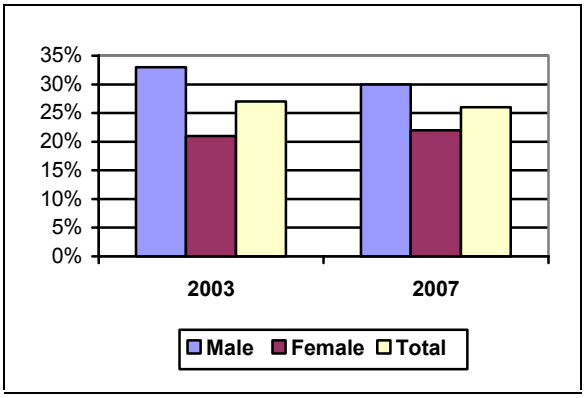
Percent youth ages 10-17 overweight or obese by gender
Data source: Child Trends analysis of National Survey of Children's Health data as provided by KIDS COUNT 2011

Being overweight or obese can have both immediate and long-term negative consequences for adolescent health. In addition to the psychosocial impact on teens, obesity increases risks for many diseases and conditions later in life, including diabetes, stroke, heart disease, arthritis, and certain cancers. The national survey categorizes children between the 85th and 95th percentile BMI-for-age as overweight, and children at or above the 95th percentile BMI-for-age as obese.

According to the most recent National Health and Nutrition Examination Survey, the prevalence of obesity among U.S. children ages 6 – 17 increased from 6% in 1980 to 19% as of 2007-2008. Rates vary by race/ethnicity, an, in Connecticut, also differ by gender.

Possible Secondary Indicators: Physical inactivity, diet quality – all by gender, race/ethnicity

Percent Connecticut Youth (ages 10-17) Overweight or Obese



- Over one-quarter (26%) of Connecticut youth were overweight or obese in 2007; nationally, 32% of 10-17 year olds were.
- Between 2003 and 2007, rates in Connecticut changed only slightly; down just one percentage point overall, up one percent for girls and down three percent for boys.
- According to the 2009 Connecticut School Health Survey, among high school students:
  - Girls are much less likely than boys to be obese (7% vs. 14%)
  - Black girls are 2.5 times more likely to be obese than White girls (12% vs. 5%)
  - Hispanic boys are twice as likely as White boys to be obese (24% vs. 12%).

INDICATOR AREA: MORBIDITY
PHYSICAL, BEHAVIORAL, AND ORAL HEALTH CONDITIONS

3. Depression (Behavioral Health)

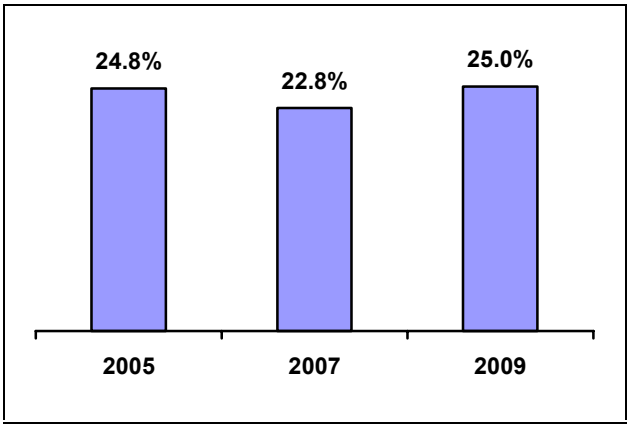
Percent high school students felt sad or hopeless for two weeks in a row
Data source: CT DPH, Connecticut School Health Survey Youth Behavioral Component, 2005, 2007, 2009

Adolescent depression can cause severe problems at home, school/work, and socially as well as adversely impact other health conditions such as asthma and obesity, and general physical well-being. Nationally and in Connecticut, about 8% of adolescents ages 12-17 experienced a Major Depressive Episode during 2007-2008. State rates ranged from a high of 10% (Wyoming) to a low of 7% (Maryland)

Youths experiencing major depressive episodes are more likely than other teens to attempt suicide and initiate alcohol and other substance use. Teen depression and suicidal behavior rates vary by gender and also differ by race/ethnicity.

Possible Secondary Indicators: Received treatment for depression, seriously considered suicide, attempted suicide – all by age category gender and race/ethnicity

Percent Connecticut High School Students Sad or Hopeless Two Weeks or More in A Row



- In 2009, one in four high school students in Connecticut felt persistently sad or hopeless, virtually same rate as in 2005 and comparable to U.S. rates.

- Adolescent girls have significantly higher depression rates than boys; the rates for Connecticut high school students in 2009 were 32.9% vs. 17.2%.
- Prevalence of teen depression also differ by race and ethnicity, with Hispanic girls having the highest rates; in Connecticut, 33.3 % of Hispanic high school students compared to 22.1% of White students experienced depression symptoms in 2009.
- In 2009, 14.1% of Connecticut high school students seriously considered attempting suicide in the past 12 months and 7.4% actually attempted suicide at least once; U.S. suicidal behavior rates were nearly the same (14% and 6%).

INDICATOR AREA: MORBIDITY
PHYSICAL, BEHAVIORAL, AND ORAL HEALTH CONDITIONS

4. Untreated Cavities (Oral Health)

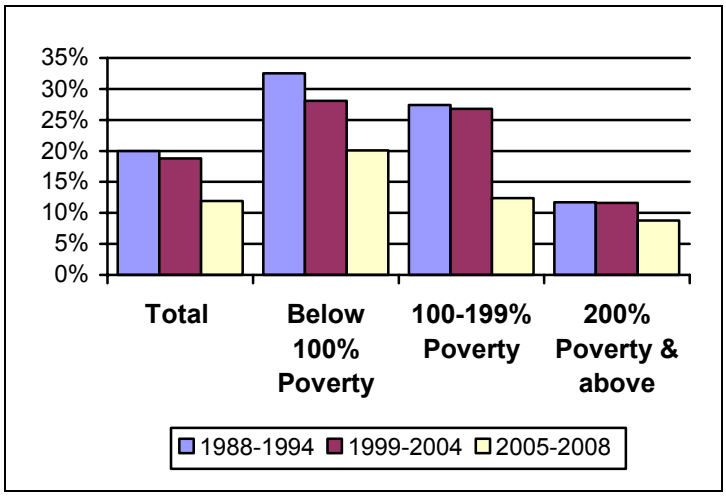
Percent youth ages 12-17 with untreated dental caries (cavities)

Data source: America's Children: Key National Indicators of Well-Being, 2011 (Federal Interagency Forum on Child and Family Statistics); not available by state at this time -- U.S. data presented below

Oral health is an integral component of overall well-being, particularly for children and adolescents. Regular dental visits and good self-care can prevent and promote treatment of oral diseases and conditions, including dental caries (cavities), the most common childhood disease. Prevalence rates for untreated caries have dramatically declined among school-age children because of community prevention efforts (e.g., fluoridated water) but cavities remain a problem among some racial and ethnic groups and those living in poverty.

Possible Secondary Indicators: Dental visit within the past year, EPSDT dental screening -- all by race/ethnicity, poverty status

Percent U.S. Youth Ages 12-17 with Untreated Cavities by Poverty Status



- One source of state data about oral health, the 2007 National Survey of Children's Health, shows 84.9% of all children in Connecticut, compared with 78.4% of children in the U.S., had a preventive dental visit in the past year.

- Nationwide, between 1999 and 2008, the percent of youth ages 12-17 with untreated cavities dropped from 19% to 12%.
- The percentage with untreated cavities among 12-17 year olds living in poverty also declined significantly during this time period.
- However, during 2005-2008, percentage of youth with untreated cavities living in poverty was twice that of 12-17 year olds with family incomes at or above 200% poverty.

INDICATOR AREA: RISK FACTORS
DRINKING, DRUG USE, TOBACCO USE, SEXUAL ACTIVITY

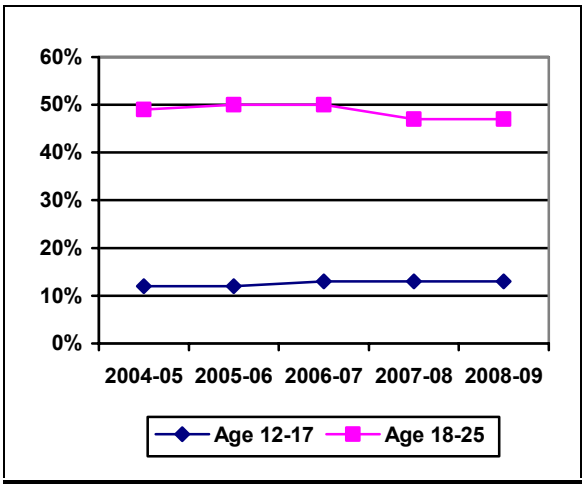
5. Binge Drinking

Percent binge alcohol use by age group
Data Source: State Estimates from National Survey on Drug Use and Health as provided by KIDS COUNT 2011

Alcohol use is associated with many negative outcomes for adolescents including injuries and death from motor vehicle accidents, fighting, and reckless behavior, as well as problems in school, the workplace, home, and community. Heavy drinking (binge alcohol use) increases the likelihood of these negative outcomes and can have serious long-term health consequences. Binge drinking for the purpose of the national survey is defined as having five or more drinks on the same occasion on at least one day in the prior 30 days.

Possible Secondary Indicators: Current alcohol use, First drink before age 13, drinking and driving -- all by gender, race/ethnicity

Binge Drinking Rates of Connecticut Youth and Young Adults (Percent by Age)



- In recent years, 13% of those ages 12-17 and around half (47-50%) of those 18-25 year old binge drink.

- Binge alcohol use rates have changed very little among Connecticut youth (age 12-17) and young adults (age 18-25) between 2004 and 2009.
- According to the Connecticut School Health Survey, among the state's high school students in 2009.
  - 26% of girls and 22.5% of boys had five or more drinks in a row (binge drinking).
  - 43.5% had at least one drink on at least one day during the month before they were surveyed.
- In 2009, the overall binge drinking rate for high school students in Connecticut and the U.S. was the same – 24.2%.

INDICATOR AREA: RISK FACTORS
DRINKING, DRUG USE, TOBACCO USE, SEXUAL ACTIVITY

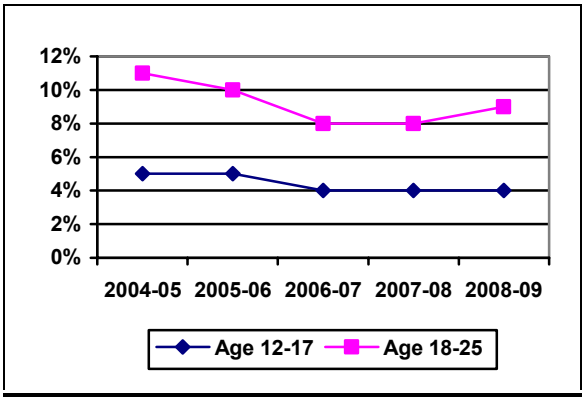
6. Drug Use

Percent illicit drug use other than marijuana in the past month by age group
Data Source: State Estimates from National Survey on Drug Use and Health as provided by KIDS COUNT 2011

Use of illegal drugs (e.g., hallucinogens, cocaine, heroin, and other narcotics, amphetamines, barbiturates or tranquillizers not under doctor's orders) can have immediate and long-term health and social consequences for adolescents. Health problems vary with the types and amounts of drugs used, but range from heart attack and stroke, to impaired pulmonary functioning, cognitive damage, and memory loss, to premature death. Like alcohol use, the use of illicit drugs has the potential for increasing teens' risky behaviors.

Possible Secondary Indicators: Marijuana use, lifetime illicit drug use, lifetime over-the-counter and prescription drug abuse -- all, by age, gender, race/ethnicity

Illicit Drug Use Rates (other than Marijuana) of Connecticut Youth and Young Adults (Percent by Age)



- From 2004 to 2009, illicit drug use (other than marijuana) declined from 5% to 4% among Connecticut adolescents ages 12-17.
  - The drug use rate for older youths (18-25), which is about double that of young teens, increased between 2008 and 2009 from 8% to 9%.
  - For both groups, Connecticut rates are comparable to U.S. rates.
- According to the Connecticut School Health Survey, among the state's high school students in 2009:
  - Rates for ever using cocaine, ecstasy, methamphetamines or heroin all were similar to those among U.S. high school students.

INDICATOR AREA: RISK FACTORS
DRINKING, DRUG USE, TOBACCO USE, SEXUAL ACTIVITY

7. Tobacco Use

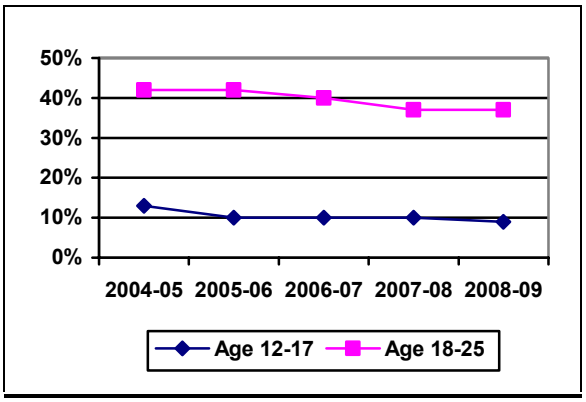
Percent any cigarette use in the past month by age group
Data Source: State Estimates from National Survey on Drug Use and Health as provided by KIDS COUNT 2011

Cigarette smoking has serious long-term consequences including the risk of premature death and smoking-related diseases. Smoking causes many types of cancer, heart disease, stroke, chronic obstructive pulmonary disease (COPD) like emphysema, asthma, hip fractures, and cataracts.

After a rapid increase in teen smoking in the early 1990s, rates of cigarette use among adolescents have steadily dropped, although certain subgroups are still more likely than others to smoke. Nationally, 19.5% of high school students smoked cigarettes on one or more days in the past 30 days in 2009. In the U.S. and in Connecticut, male high school students are more likely than females to smoke; Black high school students are significantly less likely than White or Hispanic students to be frequent cigarette smokers.

Possible Secondary Indicators: Current and frequent cigarette smoking by high school students – I by gender, race/ethnicity. Distinctions are made in Connecticut and national surveys of youth health-risk behaviors between current use – smoked cigarettes at least once in past month -- and frequent use – smoked cigarettes on 20 or more of the past 30 days.

Cigarette Smoking Rates Connecticut Youth and Young Adults (Percent by Age)



- Cigarette use among Connecticut youth ages 12–17 dropped from 13% to 9% between 2004 and 2009.
  - The cigarette smoking rate for young adults, which includes 18- and 19 -year olds, was significantly higher (37% in 2008-09) but also declined over time.
  - US and Connecticut rates are nearly the same.
- According to the 2009 Connecticut School Health Survey, among the state's high school students:
  - Almost 18% smoked cigarettes at least once in the past month
  - 19% of boys and 16.5% of girls were current smokers.
  - 20.3% of White students, 15.5% of Hispanic students, and 9.6% of Black students were current cigarette smokers.

INDICATOR AREA: RISK FACTORS
DRINKING, DRUG USE, TOBACCO USE, SEXUAL ACTIVITY

8. Sexual Activity

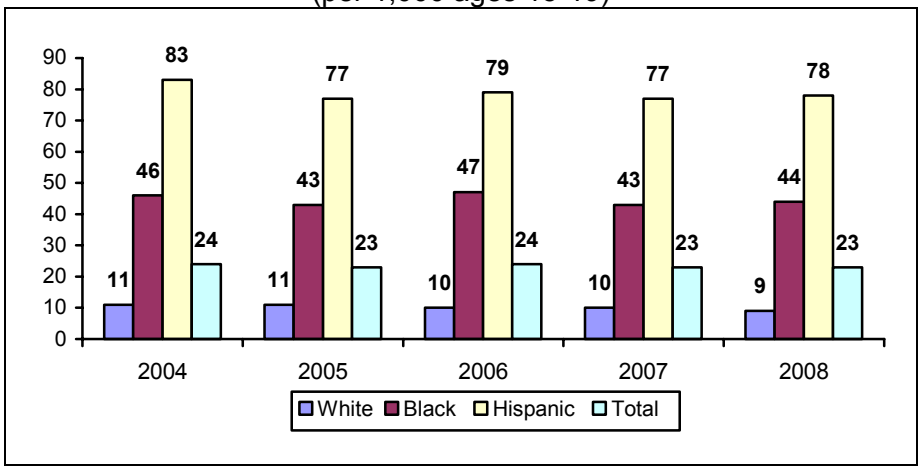
Teen birth rate per 1,000 females ages 15-19

Data Source: CDC, National Center for Health Statistics as provided by KIDS COUNT 2011

Adolescent sexual activity can pose significant emotional and physical health risks. Youth who engage in risky sexual behaviors can become pregnant and contract infections and diseases, including some with lifetime consequence. Teen pregnancy is associated with a number of long-term negative consequences, for both the child and the mother. Babies born to adolescent mothers compared with older mothers are at higher risk for low birth weight and infant mortality. Teenage mothers are more likely to experience pregnancy complications and are at high risk of dropping out of school and of living in poverty.

Possible Secondary Indicators: Teen pregnancy rates, teen births to women already mothers, STD rates, Sexual contact/intercourse, birth control use – all by race/ethnicity

Connecticut Teen Birth Rates by Race
(per 1,000 ages 15-19)



- The teen birth rate in Connecticut declined from 24 to 23 per 1,000 females ages 15-19 between 2004 and 2008; after a two-year increase, the U.S. teen birth rate dropped to 41 births per 1,000 in 2008.
- Connecticut's 2008 teen birth ranked 4th lowest among all states; Massachusetts and New Hampshire had the lowest state rate (20 per 1,000) and Mississippi had the highest (66 per 1,000).
- Teen birth rates vary substantially by race/ethnicity:
  - Nationwide, rates for Hispanic females ages 15-19 are consistently highest and were nearly twice the U.S. average for all teens in 2008 (78 vs. 41).
  - In Connecticut, the 2008 birth rate for Black teens (44 per 1,000) was almost twice the state average; the Hispanic teen birth rate (78 per 1,000) was more than three times higher.
  - Of the 2,789 Connecticut teen births in 2008, nearly half (1,353) were to Hispanic mothers.

INDICATOR AREA: PROTECTIVE FACTORS

9. Health Insurance Coverage

Percent Children and Youth (ages 6-17) Without Health Insurance

Data Source: Census Bureau, Current Population Survey as provided by KIDS COUNT 2011

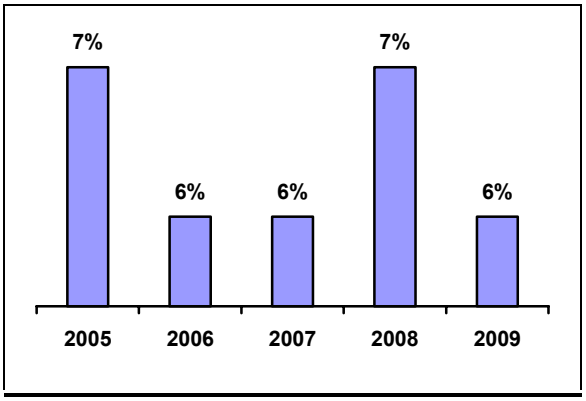
A regular and accessible source of quality health care is critical to ensuring the well-being of children and youth. Adolescents with insurance coverage, private or public (e.g., Medicaid), are more likely to obtain the preventive and primary care they need to promote and maintain good physical, behavioral, and oral health. The census defines without health insurance as not covered by private or public plans at any point during the year.

Nationally and in Connecticut, rates of uninsured children declined following creation of Children's Health Insurance Programs (CHIPs) such as HUSKY B) in 1997. By 2008, just under 10% of all U.S. children under 18 had no health insurance. However, insurance status and adequacy of coverage varies by race, ethnicity and family income. Also, national data from 2007 show adolescents ages 12-17 are more likely than young (aged 6-11) and very young (aged 0-5) children to lack adequate health insurance coverage (26.3%, 25.1%, 19.2%, respectively).

The latest census data show in 2010, 9.8% of all U.S. children under 18 (7.3 million) were uninsured for the entire year. According to an October 2011 Connecticut Voices for Children research brief, nationally, the children most likely to be uninsured in 2010 were 12 to 17 year olds (10.9%), Hispanic (16.3%) or Black children (11.0%) and children living In poverty (15.4%). An analysis by the Center for Budget and Policy Priorities found rates of uninsured children under 18 in 2009-2010 for all New England states including Connecticut were well below the national average (CT 6.4%, ME 4.2%, MA 3.4%, NH 4.4%, RI 6.0%, VT 4.4%).

Possible Secondary Indicators: HUSKY enrollment by age, race/ethnicity, Usual source of care/Have primary care physician, Adolescent vaccination rates, by gender, race/ethnicity, family income

Percent Connecticut Children and Youth (ages 6-17) Without Health Insurance



- From 2005 to 2009, the rate of uninsured children in Connecticut ages 6-17 fluctuated between 6% and 7%.

- Nationally, the rate of children ages 6-17 without health insurance in 2009 was 10%; state rates ranged from a low of 4% (Massachusetts, Vermont, New Hampshire, Hawaii) to a high of 18% (Nevada, Texas).

- Connecticut's 2010 uninsured rate for children under 18 is substantially lower than the U.S. average – 6.5% versus 9.8%; however, its rate is the highest in the New England region while Massachusetts has the lowest rate (3.4%).

- In Connecticut, the total number of children under 18 without health insurance dropped from about 58,000 in 2005 to 52,000 in 2009; approximately 36,000 Connecticut children ages 6-17 were uninsured in 2009.

STATE ADOLESCENT HEALTH CARE INFRASTRUCTURE (Rev. 12-2011)							
STATE AGENCY	**MAJOR COMPONENTS**						
	Physical Health Care	**Behavioral Health Care**	**Oral Health Care**	**Reproductive Health Care**	**Health Education**	**Prevention**	**Nutrition & Fitness**
DPH	• ***School-Based Health Centers -- SBHCs*** [School year 2008-09, 41,749 students (K-12) enrolled; $10.3 million state funds SFY11] • ***Community Health Centers -- CHCs*** [2009 served almost 290,000 patients all ages statewide; $5.1 million fed. funding] • ***Coordinated School Health – CSH*** (Healthy Connections, in partnership with SDE) [total served all ages 74,073; $100,000 federal funding annually] • ***Children and Youth with Special Health Care Needs – CYSHCN*** [Served 3,140 ages 10-18; $2.1 million] • ***Primary Care Office – PCO*** [all ages; federal funding $199,830] • ***Asthma [e.g. Easy Breathing – 1,529 children treated; Annual state funding $500,000]*** • ***InfoLine*** (contracted referral/screening services) • ***Family/maternal and child health care programs, e.g., Pregnancy Risk Assessment Tracking (PRATS)*** [all postpartum women; federal funding $100,000] • ***Sexual Violence Intervention and Prevention – SVIP*** [$990,000 all ages] • ***Sexually Transmitted Disease (STD) Control programs*** [9 clinics serve 6,000 all ages annually; $990,000]	• SBHCs • CHCs • CSH • CYSHCN • PCO • InfoLine • PRATS • SVIP • ***Injury Prevention Program – Child Sexual Abuse*** [745 children served; Annual state funding $255,287]	• SBHCs • CHCs • CSH • PCO • InfoLine • PRATS • Oral Health Office	• SBHCs • CHCs • CSH • InfoLine • PRATS • SVIP • STD • ***Family Planning*** [FY09: $1.04 million; served 39,473 clients though 12 clinics operated by statewide contractor (Planned Parenthood)] • ***Personal Responsibility Education Program – PREP (in partnership with DCF, SDE, DMHAS)*** [5 year expected federal funding $2.9 million; HIV, STD, teen pregnancy prevention for DCF youth starting in 2011]	• SBHCs • CHCs • CSH • InfoLine • PRATS • Asthma • NPAO • SVIP • STD • ***Hartford Healthy Start – HHS*** [412 enrolled low income pregnant and postpartum women in Hartford; federal funding $750,000]	• SBHCs • CHCs • CSH • CYSHCN • InfoLine • PRATS • SVIP • STD • NPAO • HHS • ***CT School Health Survey*** • ***HIV Prevention*** • ***Immunizations*** [2011 target pop. ages 10-18 = 422,262; $40.0 million for vaccines] • ***Tobacco Use*** [20,345 students served; FY10 $500,000 –none FY11] • ***Comprehensive Cancer Prev. and Control Program*** *(women age 19+)*	• SBHCs • CHCs • CSH • InfoLine • HHS • ***Nutrition, Physical Activity and Obesity program – NPAO*** • ***Communities Putting Prevention to Work*** [12 schools; fed. stimulus funds $120,000] • ***WIC*** (Women, Infants, & Children) nutrition program
DSS	• ***HUSKY (A & B)****see below*** • ***Medicaid LIA*** (covers 19 yr. olds)**	• HUSKY (A & B Behavioral Health Partnership – BHP) • Medicaid LIA	• HUSKY (A & B Dental Health Partnership –- DHP) • Medicaid LIA	• HUSKY/Medicaid • ***Teen Pregnancy Prevention Initiative - TPPI*** *[FY11: $1.8 million state; 690 capacity total]* • ***Family Planning*** (through SSBG) [FY11: $0.9 million; 5,802 served]		• TPPI • Family Planning • ***Healthy Start*** • ***Nurturing Family Network***	• ***SNAP*** (nutritional counseling)

STATE ADOLESCENT HEALTH CARE INFRASTRUCTURE (Rev. 12-2011)							
STATE AGENCY	**MAJOR COMPONENTS**						
	Physical Health Care	**Behavioral Health Care**	**Oral Health Care**	**Reproductive Health Care**	**Health Education**	**Prevention**	**Nutrition & Fitness**
	•	•	•	•		•	•
DCF	• DCF–involved covered by HUSKY/Medicaid [approx. 11,800 in A &B as of May 2011; if remain voluntarily after age 18, stay on HUSKY to 21; over age 18 who do not may qualify for Medicaid LIA] • DCF provides some direct care in facilities its operates (i.e., Riverview, CT Juvenile Training School, CCP)	• DCF-involved covered by HUSKY (BHP)/ Medicaid • **For all under 18, DCF operates/funds mental health and substance abuse services:** - **Riverview Hospital** - **CT Children's Place** - **Residential/ group homes** - **EMPS** - **Intensive In-home** - **Extended Day** - **Outpatient/ community-based** - **Care Coordination** - **Family advocacy and support** (Age 18 and over served by DMHAS)	• DCF-involved covered by HUSKY (DHP)/Medicaid	• DCF-involved covered by HUSKY/Medicaid • DCF funds: - ***Reproductive care in JJ Girls Res. Programs*** [5 providers statewide] - ***Pregnant & Parenting Girls Programs*** [5 providers statewide]	• ***School Health Ed*** *(through DCF U.S.D. #2)*	• ***Youth Suicide Advisory Committee***	
SDE	• ***School Health Care*** (School RN) [included in general state and local education funding] • ***Health Services to Pupils in Nonpublic Schools*** [FY10: $4.8 million] • ***Coordinated School Health –CSH*** (Healthy Connections, in partnership with DPH)	• ***School Behavioral Health*** (Guidance, Counseling, Social Work) [included in general state and local education funding] • CSH	• CSH	• CSH • ***Young Parents*** [2009-10 SY: $229,330; 191 teens served] • ***Support for Pregnant and Parenting Teens Project (SPPTP)*** [FFY11: $1,999,99; 5 large urban school districts]	• ***School Health Ed***. [included in general state and local education funding] • CSH	• ***Youth Service Bureaus*** [FY10: $3.6 million; 40,213 youth served] • CHS	• ***School Nutrition*** [school breakfast/lunch funding] • ***School Physical Education*** [included in general state and local education funding] • CSH

OTHER STATE AGENCIES that provide health care services to segments of the adolescent population:

Judicial Branch/Court Support Services Division (CSSD) - Juvenile detention population (under 16 currently; under 17 as of July 2012); **Dept. of Correction (DOC)** - Ages 14-19 incarcerated in adult correction system; **Dept. of Mental Health and Addiction Services** – State behavioral health services for young adults including 19 year olds

* **HUSKY A =** *Medicaid for children up to age 19 and their parents/certain adult caregivers and pregnant women:* $998 million total expended (est.) FY11 (60% federal reimbursement; returns to 50% July 1, 2011), with about 117,000 adolescents ages 10-19 enrolled (256,808 ages 0-19 enrolled as of 2/2011). Under the Medicaid program EPSDT (Early and Periodic Screening, Diagnosis, and Treatment), there are specific federal requirements for timely well-care, early detection and treatment, health education, and other primary and preventive care for children and young adults under age 21.
HUSKY B = *Connecticut's Children's Health Insurance Program (CHIP) for uninsured/not Medicaid eligible children up to age 19;* $36.6 million (est.) expended FY11 (65% federal reimbursement) with 15,000 total enrolled (Feb 2011).
** **Medicaid LIA** = *Low Income Adult*, formerly SAGA, for those over age 18 (and not aged, blind, or disabled).

Appendix D

2011 KIDS COUNT Data Book

The Annie E. Casey Foundation

Connecticut

6 OVERALL RANK

4	3	1
IMPROVED	WORSENED	UNCHANGED

KEY INDICATORS	STATE TREND			NATIONAL TREND			NATIONAL RANK
Percent low-birthweight babies	2000 7.4 2008 8.0	8%		2000 7.6 2008 8.2	8%		21
Infant mortality rate (deaths per 1,000 live births)	2000 6.6 2007 6.6	0%		2000 6.9 2007 6.8	-1%		22
Child death rate (deaths per 100,000 children ages 1–14)	2000 15 2007 12	-20%		2000 22 2007 19	-14%		3
Teen death rate (deaths per 100,000 teens ages 15–19)	2000 47 2007 44	-6%		2000 67 2007 62	-7%		7
Teen birth rate (births per 1,000 females ages 15–19)	2000 31 2008 23	-26%		2000 48 2008 41	-15%		4
Percent of teens not in school and not high school graduates (ages 16–19)	2000 11 2009 4	-64%		2000 11 2009 6	-45%		3
Percent of teens not attending school and not working (ages 16–19)	2000 N.A. 2009 6	—		2000 N.A. 2009 9	—		2
Percent of children living in families where no parent has full-time, year-round employment	2000 N.A. 2009 26	—		2000 N.A. 2009 31	—		13
Percent of children in poverty (income below $21,756 for a family of two adults and two children in 2009)	2000 11 2009 12	9%		2000 17 2009 20	18%		2
Percent of children in single-parent families	2000 27 2009 30	11%		2000 31 2009 34	10%		12

Find more state and community-level data at the KIDS COUNT Data Center: **datacenter.kidscount.org/CT**

PERCENT CHANGE OVER TIME

GETTING BETTER | GETTING WORSE

N.A.: Comparable data not available for 2000 for these indicators. Find more information and the definitions and data sources for indicators at: **datacenter.kidscount.org/databook/2011**

APPENDIX E

Commonwealth Fund State Scorecard on Child Health System Performance, 2011

CONNECTICUT

Overall and Dimension Rankings	
OVERALL	**9**
Access & Affordability	8
Prevention & Treatment	26
Potential to Lead Healthy Lives	6
Equity[a]	6

Summary of Indicator Rankings	Count
Total number of indicators	*20*
Top 5 States	6
Top Quartile	10
2nd Quartile	4
3rd Quartile	2
Bottom Quartile	4
Bottom 5 States	0

	2011 State Scorecard on Child Health System Performance					
Dimension and Indicator	Year	State Rate	All States Median Rate	Top 5 States Average Rate	Best State Rate	Rank
ACCESS & AFFORDABILITY						8
Percent of children ages 0–18 insured	2008–09	93.2	91.4	95.6	96.7	13
Percent of parents ages 19–64 insured	2008–09	88.8	83.7	92.5	95.6	9
Percent of currently insured children ages 0–17 whose health insurance coverage is adequate to meet needs	2007	76.9	77.0	81.5	83.8	28
Average total premium for employer-based family coverage as percent of median income for family household	2009	13.9	18.6	14.4	13.9	1
PREVENTION & TREATMENT						26
Percent of children ages 0–17 with a medical home	2007	62.4	60.7	67.5	69.3	18
Percent of young children (ages 19–35 months) received all recommended doses of six key vaccines	2009	71.4	74.4	81.7	84.1	36
Percent of children ages 0–17 with a preventive medical care visit in the past year	2007	95.2	87.8	96.7	97.7	5
Percent of children ages 1–17 with a preventive dental care visit in the past year	2007	84.9	79.1	85.8	86.9	4
Percent of children ages 2–17 needing mental health treatment/counseling who received mental health care in the past year	2007	78.8	63.0	77.5	81.5	2
Percent of young children (ages 10 months–5 years) received standardized developmental screening during visit	2007	16.6	18.8	35.8	47.0	39
Hospital admissions for pediatric asthma per 100,000 children ages 2–17[b]	2006	172.4	128.7	55.8	44.1	33
Percent of children with special health care needs ages 0–17 who had no problems receiving referrals when needed	2005–06	76.0	80.3	87.7	89.8	40
Percent of children with special health care needs ages 0–17 whose families received all needed family support services	2005–06	64.0	72.8	81.4	83.0	46
POTENTIAL TO LEAD HEALTHY LIVES						6
Infant mortality, deaths per 1,000 live births	2006	6.2	6.8	5.0	4.7	18
Child mortality, deaths per 100,000 children ages 1–14	2007	12.0	20.0	11.0	9.0	3
Percent of young children (ages 4 months–5 years) at moderate/high risk for developmental or behavioral delays	2007	22.7	25.8	19.2	18.6	13
Percent of children ages 10–17 who are overweight or obese	2007	25.7	30.6	24.7	23.1	5
Percent of children ages 1–17 with oral health problems	2007	23.6	25.8	21.5	20.0	9
Percent of high school students who currently smoked cigarettes[c]	2009	17.8	18.3	12.6	8.5	19
Percent of high school students not meeting recommended physical activity level[c]	2009	54.8	56.0	50.4	46.4	18

[a] The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators. Refer to supplemental *State Scorecard Data Tables* available online <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2011/Feb/State-Scorecard-Child-Health.aspx> that show data by income, insurance, and racial/ethnic groups and gaps for equity indicators.

[b] Data available for 39 states.

[c] Data available for 42 states.

Note: Refer to Appendix B in the *State Scorecard on Child Health System Performance* <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2011/Feb/State-Scorecard-Child-Health.aspx> for indicator descriptions, data sources, and other notes about methodology.